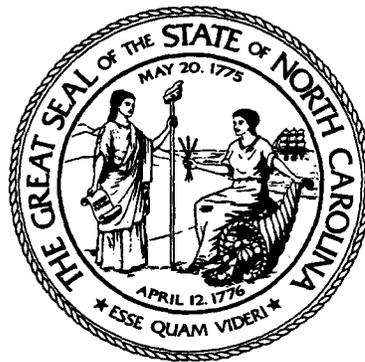


**COMMISSION TO STUDY THE DRIVERS LICENSE MEDICAL EVALUATION  
PROGRAM**



**REPORT TO THE  
1997 GENERAL ASSEMBLY  
OF NORTH CAROLINA**

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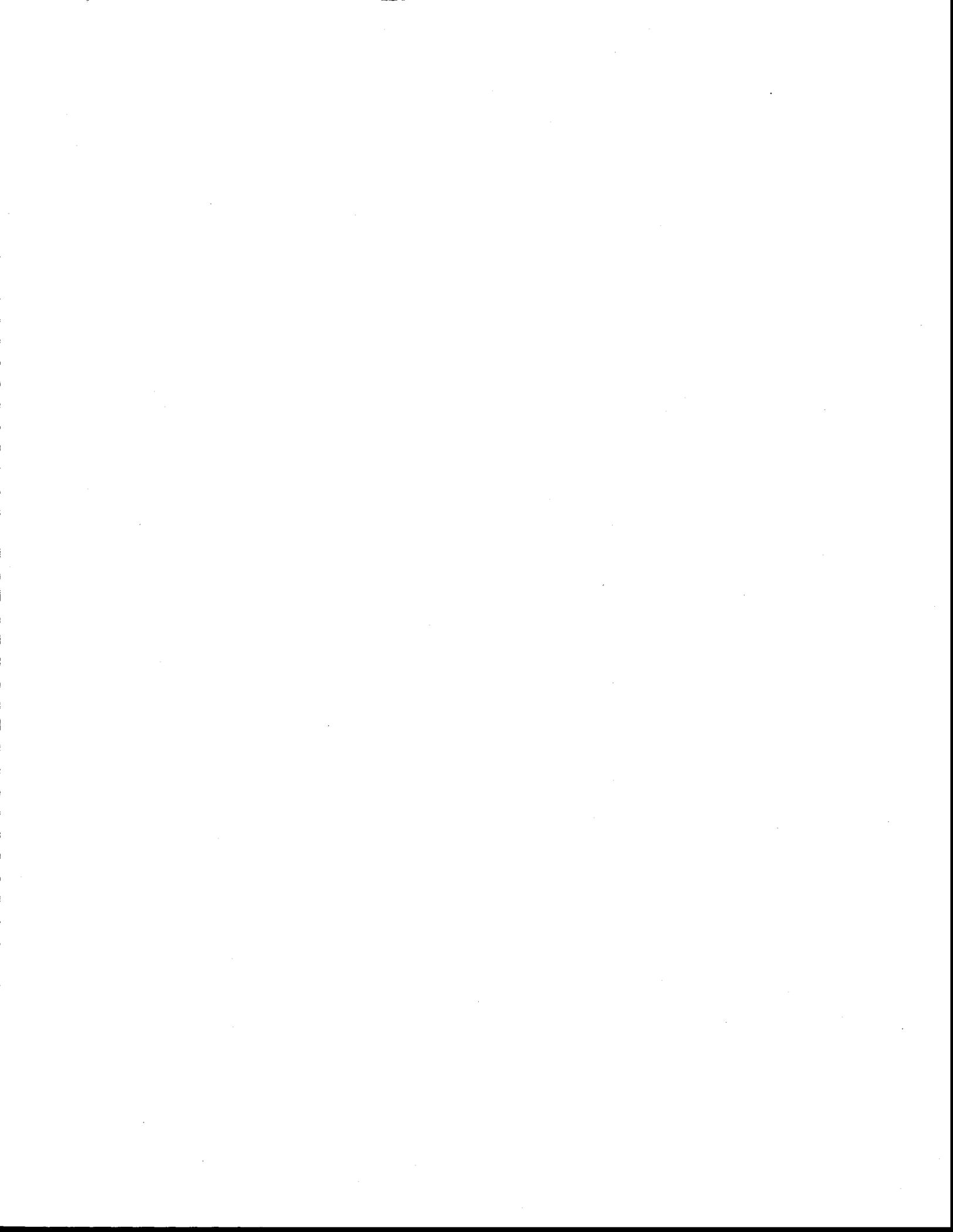
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## PREFACE

The Commission to Study the Drivers License Medical Evaluation Program was created by Section 18.17 of Chapter 324 of the Session Laws of 1995. The enabling legislation provided that the independent commission of the General Assembly should study the program operated pursuant to G.S. 20-9 for the purposes of determining:

- “(1) Whether the program should be modified or abolished;
- (2) Whether the program should be transferred entirely to the Division of Motor Vehicles rather than involving reviews by the Commission for Health Services;
- (3) How applicants for drivers licenses should be removed from the program when their conditions improve; and
- (4) Whether or not the program addresses the special needs and abilities of senior citizens.”

This statutory language arose from discussions held during the appropriations process in the Senate Transportation Appropriations Subcommittee, chaired by Senator Hoyle and in the House Transportation Appropriations Subcommittee chaired by Representatives Barbee and Bowie. These discussions focused on constituent inquiries about the operations of the Medical Evaluation Program.

The Commission members were appointed by the President Pro-Tempore of the Senate, Senator Basnight and by the Speaker of the House of Representatives, Representative Brubaker with Senator C.R. Edwards and Representative William S. Hiatt appointed as Co-Chairmen.



## COMMITTEE PROCEEDINGS

The Commission met four times in the legislative complex in Raleigh; on January 3, 1996, February 1, 1996, March 13, 1996, April 2, 1996 prior to the 1996 Session of the General Assembly. The Commission submitted, through the Co-Chairmen, a bill to be considered by the 1996 Session of the General Assembly.

The Commission met twice, on November 12, 1996 and December 10, 1996 and authorized this final report to be submitted to the 1997 Session of the General Assembly with the findings and recommendations it contains.

The following review of Committee Proceedings is intended to highlight, amplify, and enhance the minutes of the meetings which are on file in the Legislative Libraries, and not to replace them.

### JANUARY 3, 1996

At the first Commission meeting, on January 3, 1996, the Commission began its inquiries into the Medical Evaluation Program under the Division of Motor Vehicles with the technical assistance of medical personnel from the Department of Environment, Health and Natural Resources.

Wayne Hurder the Director of the Division of Motor Vehicles' Drivers License Section and Dr. Michael Moser, Director of the Division of Epidemiology of the Department of Environment, Health and Natural Resources provided an overview of the Medical Evaluation Program (MEP).

### STATUTORY AUTHORITY

The statutory authority for the MEP is found in the following General Statute Sections which state:

If an applicant shall suffer from any physical defect or disease which affects his or her operation of a motor vehicle, the Division may require to be filed with it a certificate of such applicant's condition signed by some medical authority of the applicant's community designated by the Division. (G.S. 20-7(e))

.....

The Division may issue a license to any person who is afflicted with or suffering from a physical or mental disability set out in subsection (e) of this section who is otherwise qualified to obtain a license, provided such person submits to the Division a certificate in the form prescribed in subdivision (2). Until a license issued under this subdivision expires or is revoked, the license continues in force as long as the licensee presents to the Division one year from the date of issuance of such license at yearly intervals thereafter a certificate in the form prescribed in subdivision (2), provided the Commissioner may require the submission of such certificate at six-month intervals where in his opinion public safety demands. (G.S. 20-9(g)(1))

.....

The Commissioner of Motor Vehicles, having good and sufficient cause to believe that a licensed operator is incompetent or otherwise not qualified to be licensed, may, upon written notice of at least five days to such licensee, require him to submit to a reexamination to determine his competency to operate a motor vehicle. (G.S. 20-29.1)

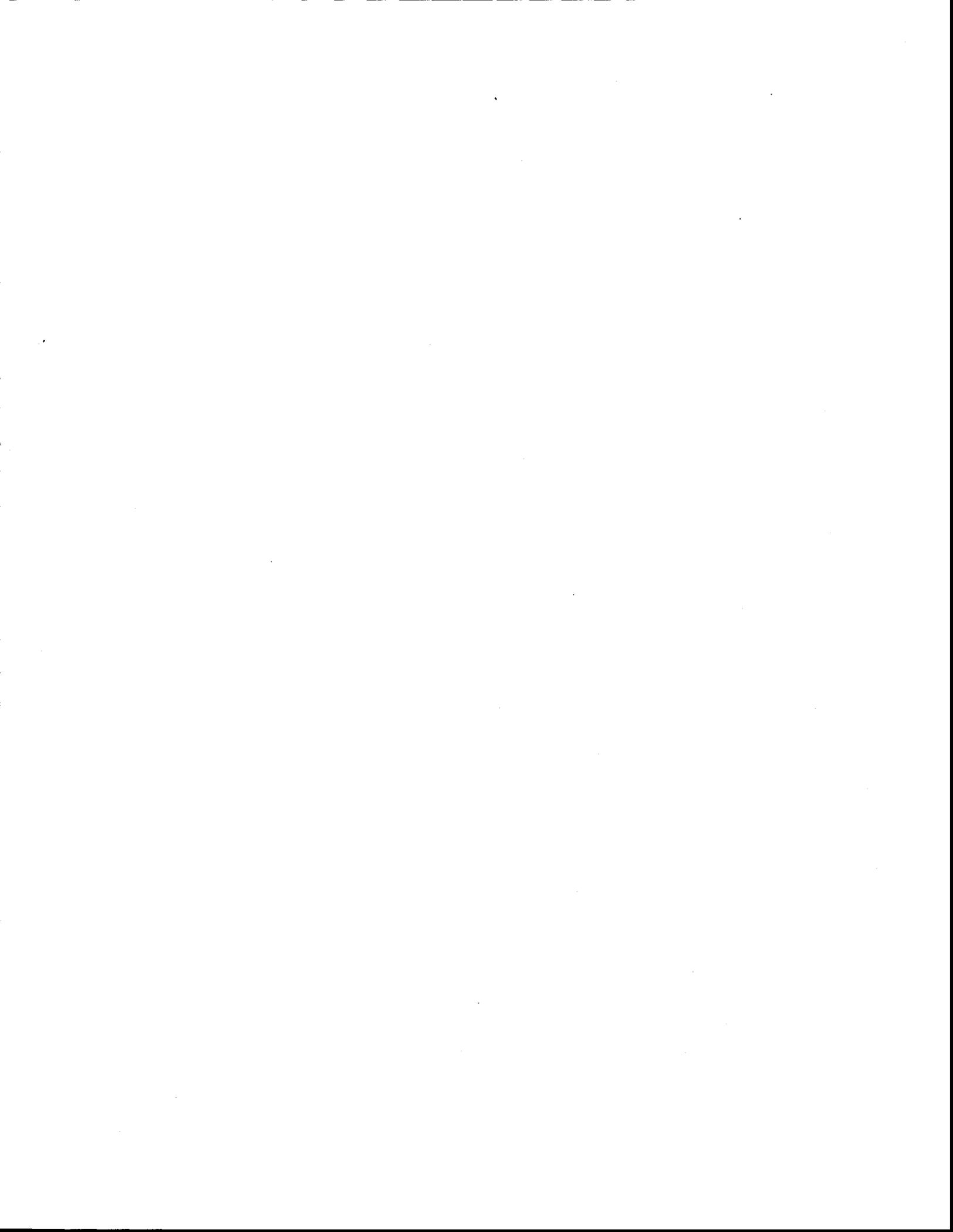
#### **SCOPE OF THE PROBLEM**

In North Carolina there have traditionally been three categories of persons who have be entered into the MEP. The first have been those drivers charged with Impaired Driving offenses. With the implementation of the Safe Roads Act in 1983 and its amendments, there is now an alternative method for dealing with persons charged with Impaired Driving offenses. Those persons are required by the courts to undergo alcohol assessments as part of the criminal justice process and their drivers licenses are either revoked or limited through court action. Prior to the passage of the Safe Roads Act, all drunken drivers were entered into the MEP, whether or not they had a chronic alcoholism problem or some other medical problem which could affect their driving abilities, and while there may still be some persons in the system as a result of drunken driving offenses, they are being screened so that those who were

entered into the program because of an offense, but who do not have some underlying medical problem, will be removed at their next case review.

The second group of drivers who are in the MEP are persons who have been declared incompetent by the courts of North Carolina after a judicial proceeding.

The third group of persons are those with diagnosed medical problems which impair their driving abilities. These persons may be suffering from chronic diseases which subject them to certain symptoms, such as cognitive impairments, physical weaknesses or impairments, or blackouts, which could adversely affect their driving and make them a public safety risk. By far the largest number of persons in this group, and a number that will increase substantially in the future, are the senior citizens of North Carolina.



## IDENTIFICATION FOR ENTRY INTO THE MEP

There are four methods by which a driver can be identified for entry into the MEP.

1. DRIVER LICENSE EXAMINER: When an applicant visits a drivers license office, the driver license examiner may notice something about the individual's physical or emotional condition that causes the examiner to believe that a medical evaluation is indicated. The applicant may answer questions on the application that would trigger a referral. The applicant's responses to questions concerning seizure activity in the past three years, blackouts, diabetes, cardiovascular problems, and other symptoms are likely to initiate issuance of a medical report form by the examiner. The applicant is then given a form to complete.

2. LAW ENFORCEMENT: As a result of an accident, traffic event, or an observation, a law enforcement officer may recommend to the Driver License Section that a driver be asked to submit to a medical evaluation.

3. WRITTEN NOTIFICATION BY OTHER PARTIES: A physician, a family member, or a concerned citizen may notify the Medical Review Branch that a person may be having some difficulty which should require evaluation of the person's medical condition. The notification must be signed and contain a return address so that the Medical Review Branch can determine that the notification is not spurious or malicious. Upon receipt of a legitimate notification, the driver's license file is sent to a drivers license examiner and a road test is scheduled with the driver to determine whether further medical evaluation is warranted. Unlike some states, North Carolina does not provide protection to the physician from liability for reporting a patient that the physician thinks is a driving hazard.

4. COURT ORDERED COMMITTAL: A court-ordered committal for substance abuse or an emotional problem automatically results in action by the Medical Review Branch. The individual's file is sent to a driver license examiner and a road test is scheduled to determine if further medical evaluation is warranted.



## EVALUATIONS

The following steps constitute how a person is evaluated for entry into and continuation in the MEP.

STEP 1. The licensee or applicant is given a Medical Review Form to be completed by a licensed physician. The cost to the driver of getting a medical professional to complete can vary from between \$50 and \$150. The cost is borne by the driver.

STEP 2. The completed medical form is forwarded by the driver to the Medical Review Branch, which records its receipt. The Medical Review Branch forwards a copy of the form (along with any previous medical data on file) to the Medical Advisor in the Driver Medical Evaluation (DME) Program in the Injury Control Section, Division of Epidemiology, Department of Environment, Health and Natural Resources. Since 1968 the Division has used the services of this state agency to provide medical advice to the Commissioner pursuant to G.S. 20-2 and G.S. 20-9.

STEP 3. The Medical Advisor staff reviews the forms and distributes the cases to an appropriate reviewer. The reviewer can be the Medical Advisor herself, a physician extender on the DME staff, or a physician on contract to DME.

STEP 4. The appropriate reviewer determines whether the data received is adequate to provide an accurate recommendation to the Division of Motor Vehicles. If the data is deemed inadequate, DME contacts the driver, in writing, and requests him to submit the additional information. This could result in the driver making another trip to the physician and incurring additional costs. The Medical Advisor may also request that a driver's license examiner conduct a road test to determine the driver's abilities. If the driver does not provide the requested follow-up information, a driver's license can be canceled or, in the case of an applicant for a new license, the application will be denied.

STEP 5. With adequate information in hand, the reviewer completes the evaluation and makes a recommendation to DMV. That recommendation may be Approval with no conditions or restrictions; Approval with conditions or restrictions; or Denial.

There are eight basic types of driving restrictions that the reviewer may recommend;

1. Daylight driving only.
2. No driving on interstate highways.
3. Speed restrictions.
4. Distance restrictions.
5. Destination restrictions.
6. Class of vehicle restrictions.
7. Vehicle modification restrictions (e.g. hand controls).
8. Medical appliance restrictions (e.g. eyeglasses, prostheses).

The drivers file is then returned to the Medical Review Branch.

STEP 6. Once the DME recommendation is returned to the Medical Review Branch, the file is reviewed by the Branch manager to determine if the recommendation is consistent with previous actions or recommendations made in similar cases.

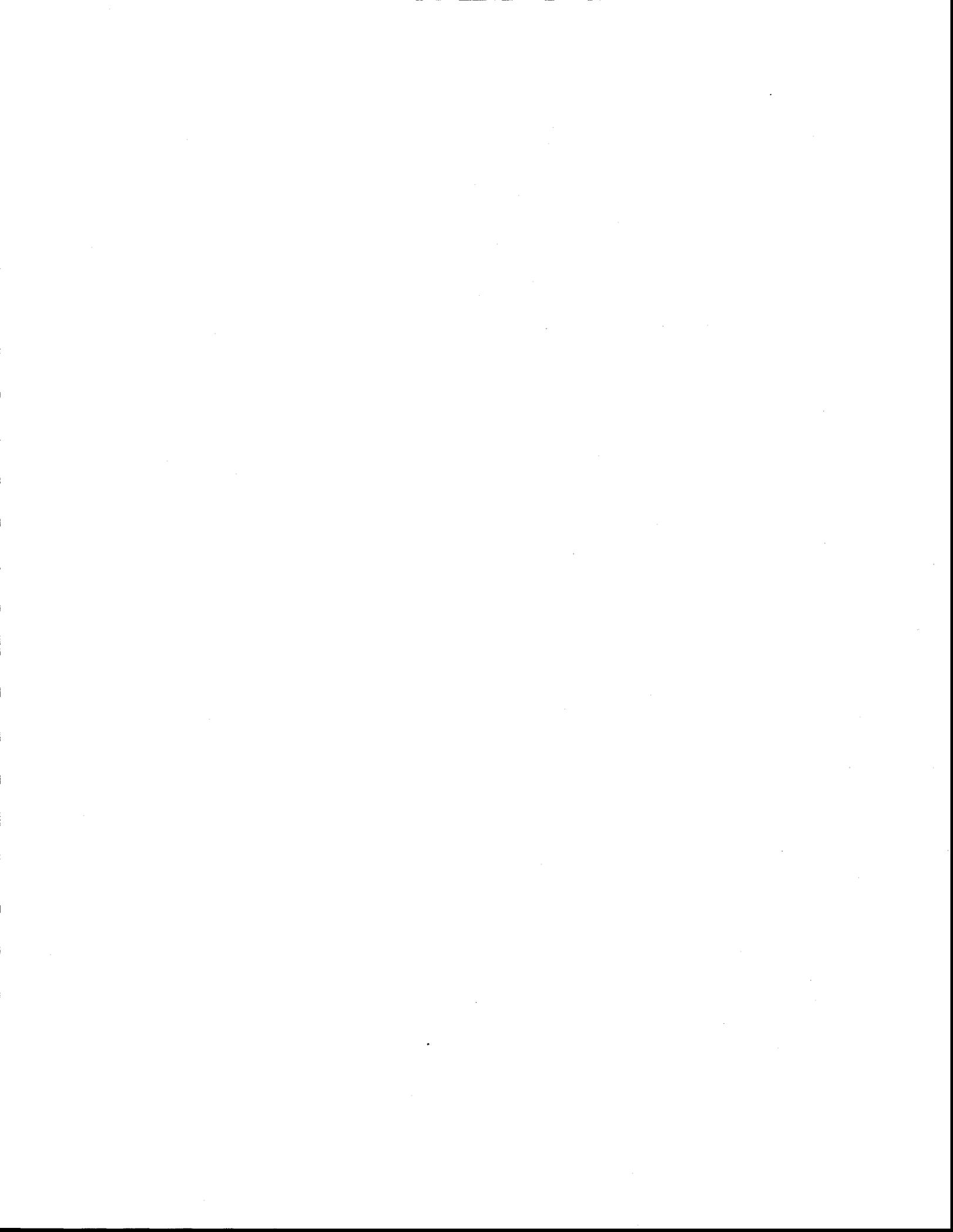
STEP 7. The driver is notified of the action. In cases of approvals and approvals with conditions or restrictions, the driver may be required to have follow-up medical evaluations done on a predetermined schedule. This is particularly true when the physical condition is not stable (e.g. deteriorating vision). The drivers license may be canceled or the application may be denied but in the case of certain medical problems (e.g. seizures), the person may be told that they can be reevaluated at a certain future time if they are asymptomatic.

### APPEALING A DECISION

Any action taken by the Medical Review Branch may be appealed. Either a denial or an approval with conditions/restrictions may be appealed. The appeal is taken before the Medical Review Board. This board consists of two persons licensed to practice medicine in North Carolina, one of whom must be a specialist in the area of the disability, and a designee of the Division of Motor Vehicles (a Medical Review Branch hearing officer).

The Medical Review Board hearings are currently held in Raleigh and Newton on a regular basis with additional hearings in Elizabethtown and Newton when the number of cases justifies it.

An appellant who does not accept the ruling of the Medical Review Board may appeal the decision to the Superior Court.



## REMOVAL FROM THE PROGRAM

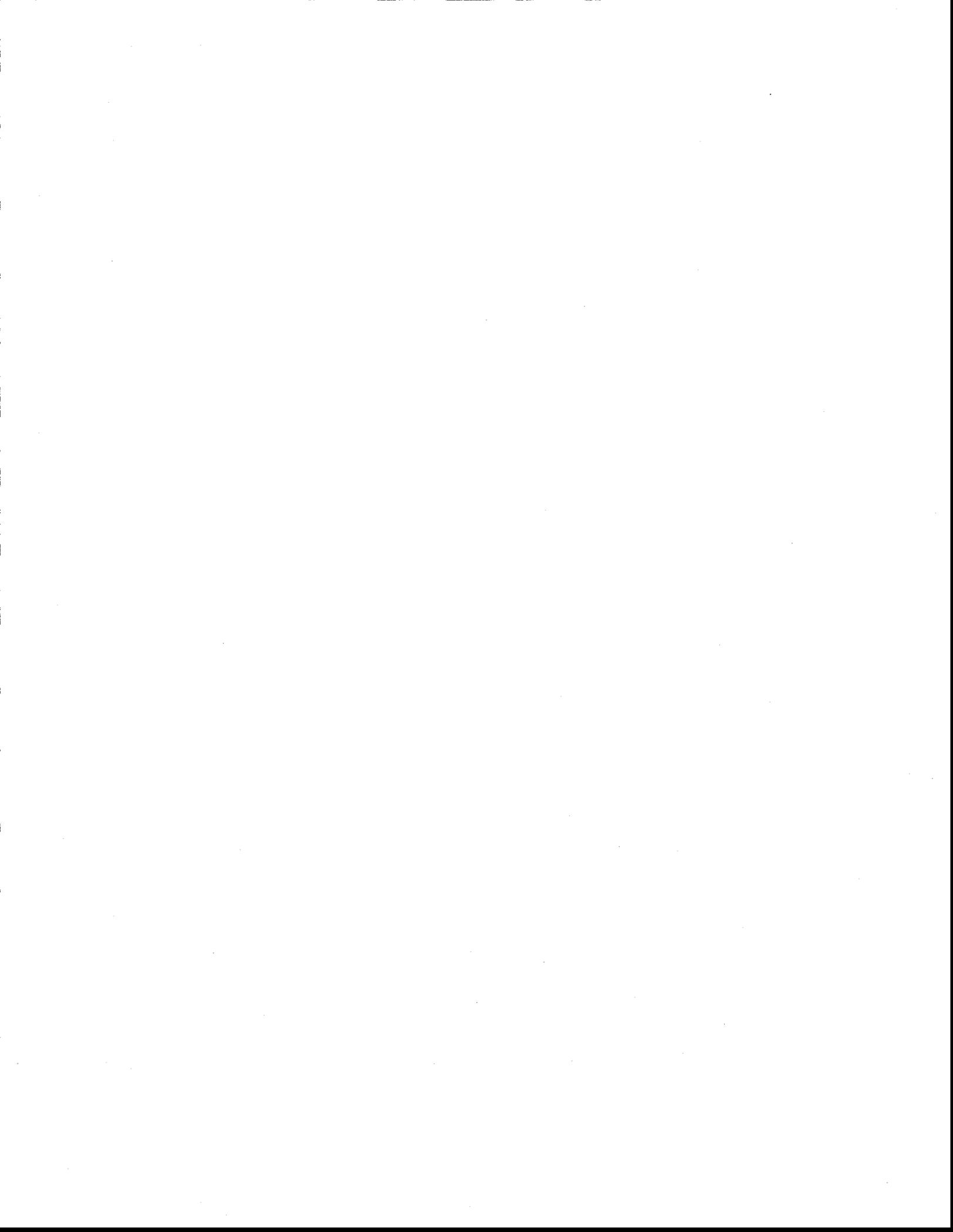
Once a person is placed in the MEP, that person is periodically reevaluated. The length of time between reevaluations depends on the physical or emotional problem that triggered the placement on the program. There are three circumstances that automatically trigger a review that can result in removal from the program.

1. During a periodic review, if a physician (or eye specialist) recommends removal from the program, that recommendation is carefully considered by the Medical Advisor (or designee) for removal from the program. Typical examples are:

- Vision problems that have corrected by surgery (e.g. cataract surgery).
- Seizure related problems, where the driver or applicant has been seizure free for four to five years.
- Diabetes, particularly where the problem is controllable through diet.

2. A customer may request strongly that we review their file for removal, and if the customer has a legitimate rationale that is corroborated strongly by the physician's statement, the Medical Review Branch Manager will review the file and make a recommendation for further processing.

3. In cases where a person was placed on the program because of Impaired Driving offenses, if the person shows that he has been alcohol-free for four years and there are no secondary problems related to alcohol, the person may be removed. If the driver is suspended for an Impaired Driving offense and is eligible for a hearing, and there is no evidence of a secondary disability, the individual is removed from the Medical Review Program in order for the Impaired Driving restoration hearing to be held. If the hearing officer clears the driver but feels further medical follow-up is necessary, the individual could be placed in the MEP again. This type of case is extremely rare, with only one being processed in the first year of the program's operation.



## **SPECIAL PROBLEMS OF THE SENIOR DRIVER**

Safe driving involves the integration of complex motor, visual, and cognitive activities. A single traffic movement results from many decisions and reactions to myriad visual (and often auditory) stimuli.

In the United States, more than 13% of drivers are over age 65. In North Carolina, more than 12% of the current driver population is over 65 years of age and it is anticipated that by the year 2030, more than 21% of the drivers will be over 65. Despite moderate deterioration of mental, motor, optic, and auditory functions, the elderly usually drive safely, probably because most driving patterns are learned and become second nature. Thus, performance is impaired only after considerable loss of function. Furthermore, the elderly tend to drive fewer miles, shorter distances, less at night, seldom during rush hours, and more slowly and cautiously. Average annual mileage declines steadily with age, decreasing 64% from age 65 to age 85.

Despite these compensations, elderly drivers have higher rates of traffic violations, collisions, and fatalities per mile driven than younger drivers, except those drivers in the under 24 year range. It has been estimated that drivers between 65 and 69 years of age have twice the number of accidents per mile driven of drivers in the 45 to 49 age range. Drivers 85 and older were 19 times more likely to be involved in a crash per mile driven than the younger drivers. Two of the most common violations, failure to yield the right-of-way and failure to obey a traffic sign, probably result from functional deficits and often lead to collisions, mainly at intersections.

Older drivers tend to fare worse in collisions. The accidents are more likely to involve multiple vehicles (which may reflect the patterns of driving, such as more daytime than nighttime driving) and to result in serious injuries and fatalities (which probably reflects underlying frailty, concurrent illnesses, and impaired recovery).

In assessing an elder's ability to drive, both public safety and the person's independence must be considered. Many states have laws concerning the obligation of physicians to report impaired drivers. Yet an inability to drive means a loss of independence because public transportation is usually impractical

for essential trips, such as food shopping and medical visits. Elders forced to stop driving rely more on their family for essential trips and reduce their social activities. These elders become depressed more often than those who continue to drive. Physicians must be aware of their legal role and their social role and medical obligations before advising elderly persons as to their fitness to undertaking driving.

Evaluation of older drivers should include functional assessment, or road tests, as well as consideration of impact of illnesses and medications on driving.

With age, many functions that affect driving may deteriorate, including muscle strength, reaction time, mobility, vision, and cognition. Decreased muscle strength, particularly grip strength, can pose a problem. An increased reaction time is also a concern. Reaction time, which increases with the difficulty or number of choices needs to be evaluated. Range of motion can affect driving. The neck is often a concern in patients with debilitating arthritic conditions because limited mobility may restrict the field of view, especially in critical traffic situations. Restrictions of the shoulder, wrist, or elbow can affect the ability to steer.

Several age-related changes in vision can affect driving. Central visual acuity frequently declines because of physiological and anatomical changes, such as the increased opacity of the lens or medical conditions, such as diabetic retinopathy. Peripheral vision also declines with age similarly to central vision. The total horizontal peripheral visual field typically declines from 170 degrees in a young adult to 140 degrees by age 50. Because the peripheral retina is less sensitive to low levels of light, twilight can be the most difficult time for driving. Drivers with peripheral vision deficits have twice as many collisions as those with normal vision. Other age-related functional deficits include poor visual adaptation to light changes, increased sensitivity to glare, declining visual accommodation and diminishing depth perception.

About 3% of elders between 65 and 74, 14% between 75 and 84, and more than 20% over 85 have moderate degrees of cognitive impairment. Those with such impairment may not fully recognize their limitations, and elderly drivers with mild to moderate dementia have a fivefold greater risk of collisions. Mild dementia causes attention deficits which play a part in these collisions. The three types

of attention deficits that contribute to collisions are selective attention, or the ability to shift focus between competing stimuli; divided attention, the ability to process two or more stimuli at once and make an appropriate response; and sustained attention, an endurance in alertness.

Functional assessment is usually considered more relevant than a medical diagnosis in determining a person's fitness to drive. Nonetheless, some conditions, such as coronary artery disease, neurologic disease, and diabetes mellitus, as well as the use of certain medications that can cause sedation warrant special consideration.

Although a doctor informing the Division of Motor Vehicles about a disability may violate confidentiality, many states sanction such actions when public safety is imperiled. About 30% of the states have laws and policies that mandate the reporting of impaired drivers and many states have laws to protect physicians from legal liability when reporting such drivers. The principal legal concern is foreseeability (the ability to predict a risk or threat to the public safety and health) which is particularly relevant for drivers with obvious impairments.

The Commission considered one of its mandates, to determine whether or not the Medical Evaluation Program should be abolished or modified, and determined that the public safety of North Carolinians requires a program to evaluate drivers with medical conditions that might affect their abilities to drive safely.

Doctor Ronald Levine, the State Health Director, raised the issue of the General Assembly passing a statute to grant licensed physicians limited immunity from civil suit for reporting medically impaired drivers to the Division of Motor Vehicles.

#### **FEBRUARY 1, 1996**

The next meeting, held on February 1, 1996 started with a report from the Committee Counsel who had attended a joint meeting of representatives from the Division of Motor Vehicles and the Department of Environment, Health and Natural Resources. He reported that, as a result of attending the meeting, he could assure the Commission that the all actual and perceived problems with the Medical Evaluation Program were being carefully considered by very committed and dedicated people and this

with the continued support of the General Assembly, the program will improve. He also indicated that after consulting with the people and agencies involved, he felt that most of the changes would be administrative in nature and the General Assembly might not have to address the issue through amendments to the General Statutes.

As a result of the potential impact of the aging driver population, the United States Department of Transportation conducted a study of the Medical Evaluation Programs in the various states.

Three states (Alaska, Idaho, and South Dakota) have no formal medical evaluation process involving either a program or a medical advisory board. Medical standards are either defined by law or have evolved over time and the Department of Motor Vehicles makes a determination based on the results of a physical examination conducted by the drivers personal physician.

Five states (Arkansas, Montana, Nebraska, New Hampshire, and Vermont) have medical review procedures in which non-medical administrative staff are responsible for reviewing driver medical qualifications. In Montana there is a review board of the chiefs of the Highway Patrol, Driver Improvement, and Driver Services with a DMV attorney to assist.

In thirteen states (Colorado, Delaware, Iowa, Kansas, Louisiana, Massachusetts, Mississippi, New Mexico, North Dakota, Rhode Island, South Carolina, Tennessee, and West Virginia) the medical review process is minimal, but a medical advisory board exists which serves as a consultant on individual cases, either at licensure or on appeal if a license has been denied.

The next group of states have medical review units, with five categories of programs within this grouping. They share the common element of having permanent, trained, non-medical staff, but differ in the level of medical input they receive. The number of professional staff vary from one to as many as 130. The size of the program depends on a number of factors including the size of the driver pool requiring medical evaluation, the overall scope of driver licensing activities, and available financial resources. Two states (Ohio and Washington) have designated medical sections responsible solely for reviewing medical issues, and evaluating applications. Neither of these states has a medical advisory

board although they do have access to ad hoc consultants. Two states (Connecticut and Oregon) have no medical advisory board but do have health department or medical association liaison.

The largest number of jurisdictions, nineteen, fit into the category of states with medical advisory boards. These states (Alabama, Arizona, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Pennsylvania, Texas, Utah, and Wyoming) have medical review units varying from one professional staff person to ten or more. In several states the unit's head is a nurse. About two-thirds of these states the Medical Advisory Board has the dual function of advising on medical and vision standards and on reviewing individual cases.

Three states (Florida, Oklahoma, and Virginia) have both an active functioning Medical Advisory Board and physician consultant hired by the Department of Motor Vehicles on a full or part-time basis.

Three states (California, North Carolina, and Wisconsin) were singled out because they have medical evaluation programs with medical review activities beyond the traditional scope. California has 20 driver safety offices throughout the state with almost 140 Driver Improvement Analysts who are responsible for reviewing and evaluating applicants for medical impairment. California's recently constituted Medical Advisory Board is responsible for establishing medical guidelines. California maintains a permanent research office with full time qualified professionals who analyze all accidents and contributes to the driver licensing policies by interacting with the Medical Advisory Board.

In Wisconsin, the Commission on Safe Transportation of the Wisconsin State Medical Society serves, at the invitation of the DMV administrator as the Medical Advisory Board. The MAB has been very active in establishing policy and guidelines for medical review which have become the DMV standards. In turn, the DMV has used the state medical society as a key channel through which to reach physicians concerning matters related to driver impairment.

North Carolina's program is described as multifaceted. In addition to a full time, professionally staffed Medical Review Unit, there is a 36-member Medical Advisory Board with broad objectives, and a separate Medical Review Board which is responsible for appeal cases.

North Carolina's program appears to be in the forefront of Medical Evaluation Programs in the United States.

#### **MARCH 13, 1996**

The next meeting of the Commission was held on March 13, 1996 in Raleigh. The Commission considered proposing a draft of a bill to the 1996 Session of the General Assembly that would provide for limited immunity from civil liability for physicians reporting patients that should be medically reviewed by the Division of Motor Vehicles.

The Commission Counsel reviewed the legislative histories of the three bills that had been introduced in the 1985, 1987, and 1989 sessions of the General Assembly, but which had not passed the initial house in any case. The Commission Counsel discussed a new bill that was based on the contents of the previous bills. G.S. 8-53, entitled "Communications between physician and patient" establishes the evidentiary rule of confidentiality between those two parties. That section provides that only the patient may waive the confidential relationship; and that the newly drafted provision would exempt the providing of the patient's name, address, and diagnosis to the Division of Motor Vehicles from the confidentiality provisions. He pointed out that there is already a limited disclosure requirement in the case of possible child abuse, as required by G.S. 8-53.1. The proposed legislation provides that the limited liability waiver language is very similar to language in G.S. 7A-550 which grants a similar waiver to physicians reporting child abuse.

The Commission considered the proposed draft and asked the Commission Counsel to redraft the bill to provide the waiver of liability for all licensed medical services personnel rather than just physicians.

#### **APRIL 2, 1996**

The next meeting of the Commission was held on April 2, 1996 in Raleigh.

The Commission considered the redrafted medical care provider limited liability waiver for reporting name, address, date of birth, and diagnosis to the Division of Motor Vehicles and the bill was recommended for introduction in the 1997 Session of the General Assembly.

The Commission then focused on the special problems of the elderly driver. The Commission Counsel reviewed the facts previously stated in this section of this report relative to the older driver. He concluded his report with the following two statements:

There is a need for balance when dealing with the elderly driver. On one hand, we have to consider the public safety issues of the elderly who have their abilities reduced as a result of natural deterioration as a result of aging and on the other hand, North Carolina does not have the comprehensive system of public transportation like some other states and larger cities.

The author of a 1994 study on this topic, Mr. Villeneuve stated: "I discovered the enormous misery that is generated by the loss or threatened loss of mobility. Many drivers simply will not discuss the future without a car....Those who were unfit to drive denied their functional status and continued to drive in defiance of their families because independent mobility was central to their definition of self.

Dr. Broadhurst, the Medical Advisor to the Drivers License Medical Evaluation Program, Division of Epidemiology, DEHNR, stressed that her Department tries to allow drivers with medical impairments to drive as long as possible. She said that the focus is on maintaining autonomy and independence. She discussed maximizing highway safety for the older driver and some of the medical impairments commonly found in the older driver.

She reviewed nationwide trends of the elderly driving population and said that these trends apply to North Carolina, as well:

- By the year 2020 the number of drivers over the age of 75 will double to more than 17 million nationwide.
- Fifty percent (50%) of this population will suffer impairments such as cataracts, dementia, and other illnesses that will impact their driving ability.
- Eighty percent (80%) of these people will take medication that may possibly impair their ability to drive.
- These drivers will drive over 84 billion miles a year, and 88% of them will rely on private automobiles to get around.

She also highlighted positive points of the older driving population. She said that they drive the least number of miles and have the lowest number of accidents. They rarely drive without their license, rarely speed, rarely drink and drive, and rarely disregard traffic laws. She concluded that the problem is not the age of the driver, but that advanced age is a marker for the medical impairments that they tend to have, that these drivers have more accidents per miles driven, and that .46% of them are likely to die as a result of an accident as compared with .21% in the other driving populations when involved in accidents.

Dr. Broadhurst suggested that in the future, the following licensing solutions, used in other states, should be considered in North Carolina:

- Frequent renewal intervals for older (65 or older) and younger (under 21) driving populations.
- Imposed vision, knowledge, and road tests for drivers over 65 years of age.
- Random medical examinations for drivers over 65 years of age.

The Commission heard from Cliff Crandell, AARP State Coordinator for the 55Alive/Mature Driving Program. He described the program to the Commission as a program that is specifically based on the needs of drivers over 50 years of age. The curriculum includes recognizing the mental and physiological changes that occur with aging and how to compensate for them while driving, review of driving principles, review of road signs, rules of the road, special driving situations, medications and alcohol, and warning signs that indicate when it may be time to quit driving.

He noted that the AARP recognizes the problems of the older driver, but takes the position that age is not a fair or valid criterion on which to base driver licensing because of the wide variation in the rate, timing, and severity of the aging process.

He concluded by saying that while most efforts to solve the problems of the elderly driver result in restricting or limiting driving, AARP has developed an 8 hour classroom refresher course that is specifically designed to help the older driver recognize the reduced visual acuity, hearing loss, and

slower reaction time that comes with aging, and how to compensate for them. This, he said, rewards all of us with safer streets and highways, reduced accidents, and lower demands on the health care system.

#### **NOVEMBER 12, 1996**

At this meeting the representatives of the Division of Motor Vehicles and the Department of Environment, Health and Natural Resources reviewed the contents of the joint proposal for the enhancement of the Medical Evaluation Program contained in Appendix C of this report. Each of the recommendations was discussed and it was decided to recommend two bills to the 1997 General Assembly.

The Committee recommended that the bill that was recommended by the Committee to the 1996 Session of the General Assembly (SB 1104) which was not enacted, be reintroduced for reconsideration.

The Committee recommended that the budgetary requests to support the programmatic improvements in the Medical Evaluation Program, including additional funds for personnel, equipment, public education, personnel education, and research studies, as described in Appendix C be prepared as a bill for introduction in the 1997 Session of the General Assembly.

#### **December 10, 1996**

The Committee heard from the Butch Elkins, Legal Counsel to the Governor's Advocacy Council for Persons with Disabilities on that body's concerns about granting limited immunity from liability for medical care providers who inform the Division of Motor Vehicles of the name, address, date of birth, and diagnosis of persons who might need a review of their driving abilities due to disabilities. After much discussion, Senator Horton clearly explained the need for the bill in that some communications between medical care providers and patients are confidential pursuant to statute. The patient has the right to determine whether or not the information is revealed and if the medical care provider reveals the information without the prior authorization from the patient, the patient could sue the medical care provider for malpractice. The proposed bill would allow medical care providers constrained by statute from revealing information to DMV, to provide the DMV with the name, address, date of birth, and

diagnosis when, in the judgment of the medical care provider it is necessary for the safety of the patient and the motoring public that a review of the patient's driving abilities be undertaken. The information provided to the DMV may trigger that inquiry into the patient's driving abilities, and that inquiry procedure contains all of the due process protections that the Governor's Council was concerned about. The Committee directed that the bill be rewritten to apply only to those medical care providers who are limited by statute from freely revealing the information to the DMV.

The Committee voted that with the directed changes, that the final report be prepared by the Committee Counsel and submitted to the 1997 Session of the General Assembly for consideration.

## FINDINGS AND RECOMMENDATIONS

**THE COMMISSION FINDS** that the Medical Evaluation Program administered by the Division of Motor Vehicles with the assistance of the Department of Environment, Health and Natural Resources is a very important program, which will become increasingly critical in the future, with the aging driving population, and that it should be enhanced to assure greater public safety on our highways.

**THE COMMITTEE RECOMMENDS** that the Medical Evaluation Program in the Division of Motor Vehicles be continued and that the programmatic changes and improvements that have been begun be continued in the future.

**THE COMMISSION FINDS** that the joint recommendations of made by Michael Moser, M.D., Director, Division of Epidemiology and Wayne Hurder, Director, Driver License Section, DMV contained in a document entitled "Proposals to Improve North Carolina's Driver Medical Evaluation Program," dated November 4, 1996, and incorporated in this report as APPENDIX C be included in a bill to be introduced in the 1997 Session of the General Assembly.

**THE COMMISSION RECOMMENDS** that the proposals contained in APPENDIX C of this report be fully funded by the 1997 General Assembly as an investment in continuing and enhancing the public safety of this state by allowing for the better identification of those individuals that may pose a risk to the safety of the motoring public because of medical conditions that limit their driving abilities.

**THE COMMISSION FINDS** that certain medical care providers are prevented, by statute, from identifying patients that may have difficulties driving motor vehicles, and may pose a risk to the safety of the motoring public and that the attached draft, found in Appendix B, which will aid the identification of persons who should be subject to the Medical Evaluation Program be submitted to the 1997 General Assembly for consideration.

**THE COMMISSION RECOMMENDS** the passage of the attached draft which would grant to medical care providers constrained by statute from revealing otherwise confidential information to the Division of Motor Vehicles a limited waiver from legal liability for identifying to the Division of Motor

Vehicles the name, address, date of birth, and diagnosis of persons that may pose a threat to the motoring public because of identified medical conditions that may affect their driving abilities.

**APPENDIX A**

**COMMISSION MEMBERSHIP**

Senator C. R. Edwards, Chairman  
1502 Boros Drive  
Fayetteville, North Carolina 28303

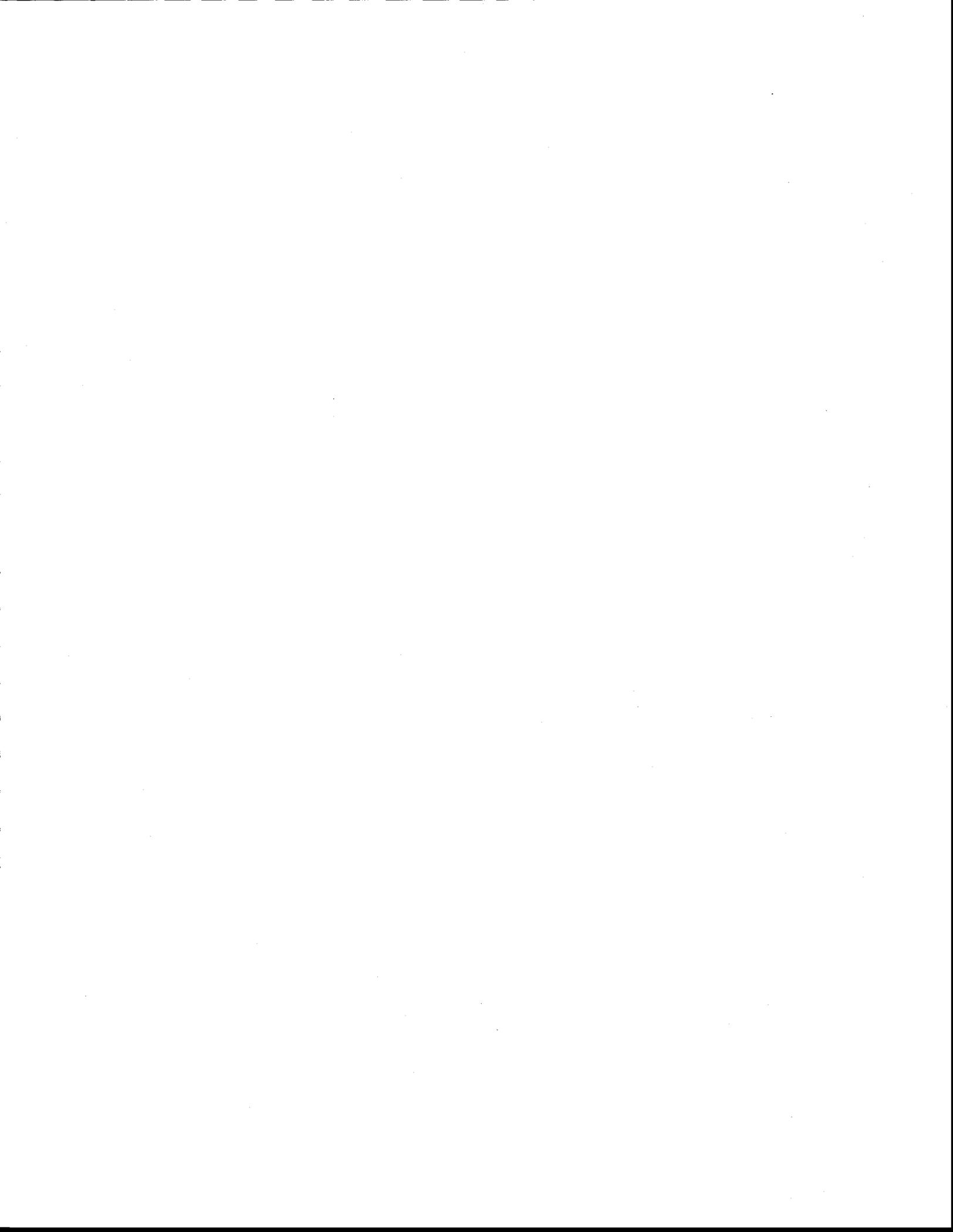
Representative William S. Hiatt, Chairman  
P.O. Box 1378  
Mt. Airy, North Carolina 27030

Senator Hamilton C. Horton, Jr.  
324 Spring Street  
Winston-Salem, North Carolina 27101

Representative J. Sam Ellis  
3513 Auburn-Knightdale Road  
Raleigh, North Carolina 27610

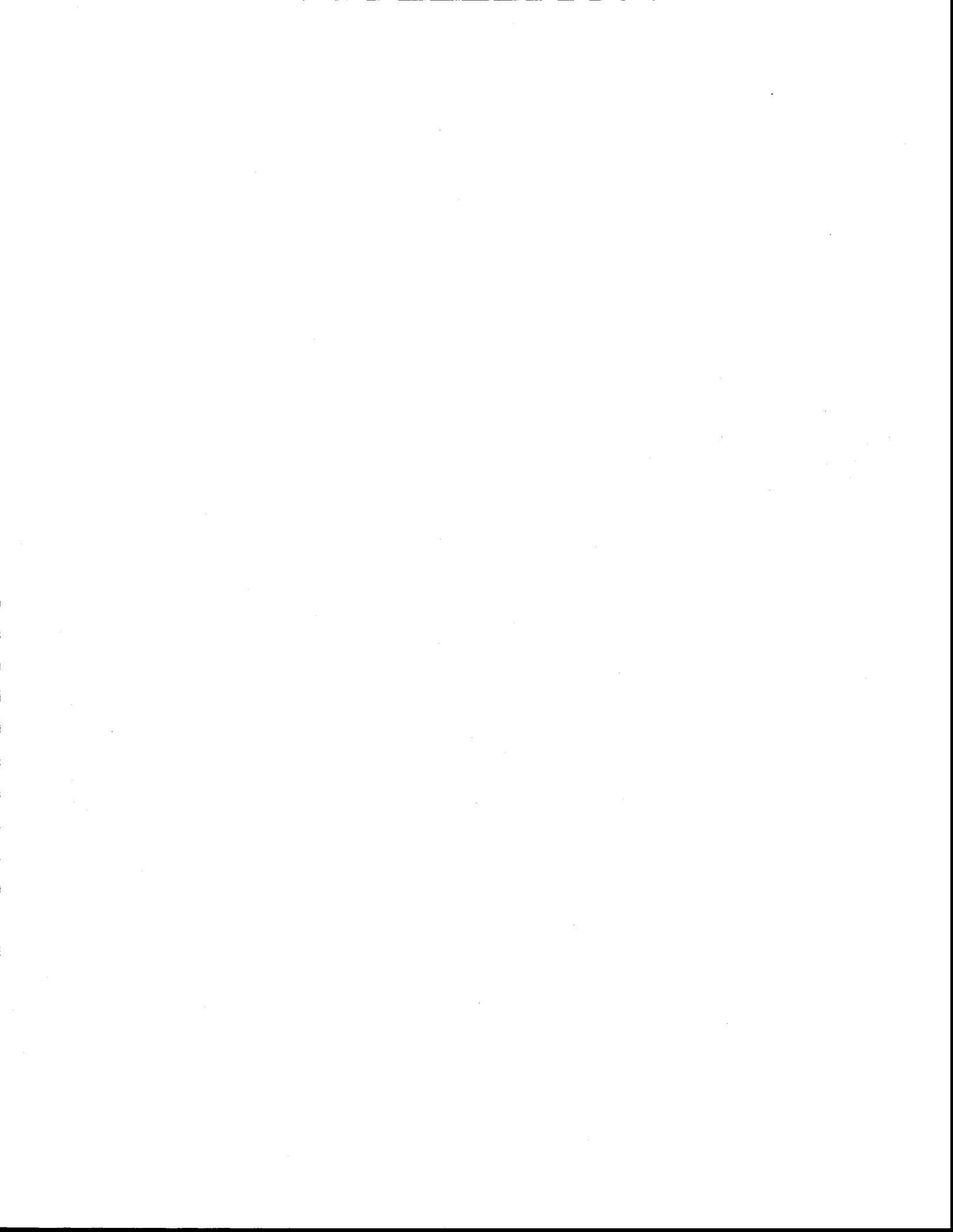
Senator David W. Hoyle  
P.O. Box 2494  
Gastonia, North Carolina 28053

Representative Liston B. Ramsey  
Box 337, Walnut Creek Road  
Marshall, North Carolina 28753



**APPENDIX B**

This appendix contains the two bills recommended by the Commission to the 1997 Session of the General Assembly.



GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1996

H

D

1997R1DRF01698.1

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

Short Title:

(Public)

Sponsors: Representative Hiatt

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LIMITED IMMUNITY FOR PHYSICIANS AND PSYCHOLOGISTS PROVIDING MEDICAL INFORMATION ON DRIVERS TO THE COMMISSIONER OF MOTOR VEHICLES.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 20 of the General Statutes is amended by adding a new section to read:

**“§ 20-9.1. Physicians and psychologists providing medical information on drivers with physical and mental disabilities.**

**(a) Notwithstanding G.S. 8-51 for physicians and G.S. 8-51.3 for psychologists, or any other law relating to confidentiality of communications between physicians or psychologists and their patients, a physician or a psychologist duly licensed in the State of North Carolina may disclose to the Commissioner information about a patient who has a mental or physical disability that the physician or psychologist believes may affect the patient’s ability to safely operate a motor vehicle. This information shall be limited to the patient’s name, address, date of birth, and diagnosis.**

**(b) The information provided to the Commissioner pursuant to subsection (a) of this section shall be confidential and shall be used only for the purpose of determining the qualifications of the patient to operate a motor vehicle.**

**(c) A physician or psychologist disclosing information pursuant to this section is immune from any civil or criminal liability that might otherwise be incurred or imposed based on the disclosure provided that the physician or psychologist was acting in good faith and without malice. In any proceeding involving liability, good faith and lack of malice is presumed and must be proven by the complainant.”**

Section 2. This act is effective when it becomes law.

**DRAFTER'S NOTES:** Current statutes provide that of all of the medical care providers, only physicians and psychologists have a duty to keep confidential all information they derive from their patients. It would be an act of malpractice for a doctor or a psychologist to reveal any of this information without the prior approval of the patient. There may be some circumstances when the doctor or the psychologist feels that it would be inappropriate to seek the prior approval of the patient to release the information. Without this bill, an act of malpractice would subject the doctors and psychologists to possible lawsuits for breaching their duty of confidentiality.

This bill will allow the doctors and psychologists to reveal the only name, address, date of birth, and diagnosis of a patient to the Commissioner of Motor Vehicles if the doctor or psychologist believes that the patient has a mental or physical condition that might affect their driving abilities. The information, when provided to the Commissioner becomes confidential and is not treated as a public record so it cannot be used except for the Medical Evaluation Program. Once the information is received by the Commissioner, and verified, then the procedures for placing the person in the Medical Evaluation Program would be triggered, with all of the due process notices and hearings that are a part of the Program.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H

D

1997R1DRF01701.1

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

Short Title: Medical Evaluation Program Funds

(Public)

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Sponsors: Representative Hiatt

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Referred to:

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A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE CONTINUATION AND ENHANCEMENT OF THE MEDICAL EVALUATION PROGRAM IN THE DIVISION OF MOTOR VEHICLES AS RECOMMENDED BY THE DRIVER MEDICAL EVALUATION PROGRAM STUDY COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the Highway Fund to the Division of Motor Vehicles the following funds for the designated purposes for the 1997-98 fiscal year to implement the recommendations of the Driver Medical Evaluation Program Study Commission.

- (1) Fifty-five thousand dollars (\$55,000) for an education program to assist older drivers based upon the American Association of Retired Persons' (AARP) "55 Alive" Program; a new collaborative effort between the AARP, the Division of Motor Vehicles (DMV), the Driver Medical Evaluation Program (DME), and the Injury Control Section of the Department of Environment, Health and Natural Resources (DEHNR).
- (2) Ten thousand dollars (\$10,000) to print and distribute educational pamphlets to explain the Driver Medical Evaluation Program and how participants can be released from the program.
- (3) Five thousand dollars (\$5,000) to establish and maintain a Web Page on the Internet for DMV, including information on the Driver Medical Evaluation Program.
- (4) Seventy-nine thousand eight hundred eighty-nine dollars (\$79,889) to fund an additional DME Health Physician II to review cases.
- (5) Twenty-nine thousand two hundred dollars (\$29,200) for a contract with SIPS for computer support for DMV's Medical Imaging System (\$10,400) and analyst programming services (\$19,400).

- (6) Twenty-five thousand two hundred dollars (\$25,200) for point to point data communications costs to comply with Medical Imaging System operating requirements.
- (7) Three thousand dollars (\$3,000) to provide for annual training for members of the Medical Review Boards to keep them current on medical information included in the updated N.C. Physician's Guidelines for Driver Medical Evaluation.
- (8) Fifty thousand dollars (\$50,000) for ongoing research to establish and verify the effectiveness of the Drivers Medical Evaluation Program in preventing accidents and improving the safety of the motoring public.
- (9) Seven thousand dollars (\$7,000) to allow the DMV to periodically conduct Medical Review Customer Satisfaction Surveys before and after the Medical Imaging System is fully implemented to document the improvements in customer service and to seek feedback from affected drivers.

Section 2. This act is effective when it becomes law.

**DRAFTER'S NOTES:** This bill provides the funding to implement the joint recommendations of the Division of Motor Vehicles and the Department of Environment, Health and Natural Resources for the continuation and enhancement of the Driver Medical Evaluation Program. The full text of the recommendations presented to the Commission begin on the next page of this report.

State of North Carolina  
 Department of Environment,  
 Health and Natural Resources  
 Division of Epidemiology

James B. Hunt, Jr., Governor  
 Jonathan B. Howes, Secretary  
 Michael Moser, M.D., M.P.H.



Injury Control Section  
 (919) 715-6443

**MEMORANDUM**

TO : Ken Levenbook, Legislative Services Office, N.C. General Assembly

FROM : Michael Moser, MD, Director, Division of Epidemiology  
 Wayne Hurder, Director, Driver License Section, DMV

DATE : November 4, 1996

SUBJECT : Proposals to Improve North Carolina's Driver Medical Evaluation Program

Based upon joint discussions between the staffs of Division of Motor Vehicles (DMV) and the Driver Medical Evaluation (DME) Program, there are three broad objectives that we believe will improve the safety of the driving population. They are as follows:

**OBJECTIVE 1 : To increase our education efforts for drivers, family members and physicians on when and how it would be appropriate for individuals to self-restrict their driving privileges.**

The Driver Medical Evaluation Program currently reviews about 20,000 cases per year. A sizeable number of these cases are elderly drivers who have a least one medical condition that warrants review. State census projections estimate that between 1990 and 2110, the state's population of 50 years and older will increase by 57 percent to nearly 2.7 million or about one out of every three North Carolinians. This increase will be especially great at ages 85 and older as that population is expected to double to over 153,000. While older drivers are not inherently unsafe drivers, their physical ability and mental alertness may deteriorate over time until it affects their capacity to drive safely. Family members and personal physicians can and should play an important role in counseling the physically frail or cognitively impaired driver concerning their limitations and the need to self-restrict their driving patterns or to stop driving.

- A) Re-introduce the Limited Immunity Bill (S-1104) from the short session.
- B) Expand recent efforts to educate physicians and other health care providers on their role in counseling drivers/family members on appropriate self-restriction (conferences, annual meetings, Area Health Education Centers continuing education programs, etc.). Full implementation of this activity will require

additional staff time. See request under Objective 2-A

- C) Pilot an educational campaign aimed at older drivers based upon AAA's "55 Alive" program. This would be a new collaborative effort between AARP, DMV, DME and the Injury Control Section. (Est. cost \$ 50-60,000 per year )
- D) Conduct educational programs for DMV driver examiners and Highway Patrol Officers on the appropriate guidelines for referring drivers to the Driver Medical Evaluation Program (presentations at annual meetings, training sessions, etc.).
- E) Print and distribute education pamphlets on the Driver Medical Evaluation Program. (Why drivers are referred to the program, examples of what medical conditions may warrant a referral, consequences, appeals rights and discharges). (Est. costs \$10,000 per year)
- F) Review text of DMV-DME correspondence with drivers referred to the Driver Medical Evaluation Program for clarity, brevity, etc. Include or add information sheet or the DME pamphlet on why they have being followed and under what circumstances they could be dropped from the program.
- G) Create WEB page for DMV to provide driver license information to the public as well as information on the Driver Medical Evaluation Program. Specific guidelines on physical conditions and impairments could thus be made available to drivers and their families as well as to medical care providers who wish to counsel their patients. Site would be maintained by DMV with DME input. (Est. costs \$5,000)

**OBJECTIVE 2 : To reduce the existing backlog of DMV cases to be reviewed and to obtain SIP's computer support for DME's conversion to the new DMV Medical Imaging System.**

DME must be sufficiently staffed to process and review an annual case load of 20,000 cases. Currently there are only two FTEs funded in DME to review cases including one that is the Section Chief. To be minimally staffed, DME needs to have three FTEs to review about 150 cases each per week (150 x 48 weeks x 3 reviewers = 21,600 cases). At present, DME is contracting with two physician assistants for the review of cases (at \$4 per case) using the lapsed salary from vacant DME positions. Once DME is fully staffed, both the increasing case load and the growing complexity of the cases will necessitate that existing staff focus solely on case reviews to the exclusion of quality assessment, data analysis, review, physician and family education, etc.. In addition while the impact of the Medical Imaging System will improve the mechanics (legibility of records, linking and accessing of records etc.) of case review, it will actually slow down the review process while the reviewer accesses the different DMV computer screens to reference records and to enter recommendations.

System Integration support is needed from SIPS for the installation, conversion and operational support of DMV's new Medical Imaging System in DME.

- A) Fund an additional DME physician to review cases (Est. costs of a Public Health Physician II is \$65,452 in salary and \$14,437 in fringe benefits).
- B) Contract with SIPS for DME OS/2 computer support of DMV's Medical Imaging System ( \$20 per hour x 10 hours per week x 52 weeks = \$10,400) and for SIPS analyst programming services (\$80 per hour for six weeks = \$19,400).
- C) Increased DME point to point data communications costs to comply with the Medical Imaging System operating requirements (\$ 2,100 per month x 12 months = \$25,200)

**OBJECTIVE 3 : To develop a joint (DME/DMV) quality assurance program that values both the personal dignity of drivers and the safety needs of the driving public.**

Program staff will jointly examine each step in the DMV-DME review and evaluation cycle to determine if there are changes that can simplify the process for all participants while maintaining high standards of public health safety. The full implementation of the Medical Imaging System will permit the tracking of program outcomes that have previously not been available for review by senior DMV-DME management. Quality assurance efforts will also need to encompass the concepts of peer review between DME case reviewers, the DMV's Medical Evaluation Coordinator and the members of the Medical Review Board.

- A) DMV-DME staff will jointly need to design monthly reports that provide useful summary program statistics and customer service benchmarks. For example, DME would like to have a monthly quality control check on the final disposition of cases by the DMV's Medical Coordinator when DME's recommendations are either changed or modified as well as those situations when cases which are being decided upon without any DME review or recommendation.
- B) DME medical staff need to constantly stay abreast of current trends in driver medical evaluation to ensure that the N.C. Physician Guidelines for Driver Medical Evaluation are kept current with the "state of the art" medical practices and so that DME can make sound recommendations on driver cases and to private practioners who counsel their patients based on DME guidelines. The above guidelines will need to be updated, reprinted and distributed to physicians on a regular basis (3 year cycle) to keep current with changes in medical practice. Physician members of the Medical Review Boards need to be included in this process through annual meetings of board members.(Est. costs \$3,000 / yr)
- C) Perhaps most importantly, we need to conduct research into how implementing the 1995 Physician Guidelines have affected crash rates among drivers assigned to the Driver Medical Evaluation Program. One method to accomplish this

would be to take the driving histories of all new drivers referred into the DME program in 1996 and compare their driving history for 2 years before and 2 years after their DME evaluation to examine the crash history and violation rates of these drivers. A similar design was used successfully in the early 1980s to evaluate the NC DME program. That study did show the program's success in reducing crash rates for nearly all medical conditions studied. The study design has been published and the methodology peer-reviewed. Imaging could be used to facilitate this process, however, extensive personnel and time outside the scope of the current DME budget will be necessary to complete the study. This is a lengthy and difficult process and few states have the capacity or inclination to undertake such a complex study. But its results would yield benefits to N.C. driving public and attract nationwide interest (Est. costs by Highway Safety Research Center is \$50,000).

- D) DMV would like to periodically conduct Medical Review Customer Satisfaction Surveys before and after the Medical Imaging System is fully implemented to document their improvements in customer service, seek feedback on participants attitudes, etc. (Est.costs \$7,000).

Please note that while we have attempted to assign an estimated cost to each item, there are hidden time-manpower costs associated with each proposal that will affect DME's capacity to review its caseload of 20,000 cases per year. The funding requests listed under Objective 2-A are based primarily on estimates of capacity needed to deal with quality assurance expansion and the new DMV imaging technology.

If there are any questions about any of the proposals or if you wish additional details, please let us know. We look forward to a discussion of these items when you have the opportunity.

